

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-043259

FILED VS DEC 13 1960

Registration District No. 316 Primary Registration District No. — Registrar's No. 480 STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY <u>St. Francois</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Francois</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>R.R.# 1 Bonne Terre</u>		c. CITY OR TOWN <u>Bonne Terre</u>	
Length of stay in 1b <u>4 Mos.</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>R.R.#1 Bonne Terre, Mo.</u>		d. STREET ADDRESS (If outside, give location) <u>R.R. # 1,</u>	
Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>G.</u> Last <u>Raue</u>		4. DATE OF DEATH Month <u>December</u> Day <u>8</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>6/16/1868</u>
9. AGE (last birthday) <u>92</u>		IF UNDER 1 YEAR IF UNDER 24 HR Months <u>5</u> Days <u>22</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired Farmer</u>	
11. BIRTHPLACE (City and state or country) <u>Randolph Co. Ill.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>William Raue</u>		13b. MOTHER'S MAIDEN NAME <u>Martha Charville</u>	
14. NAME OF HUSBAND OR WIFE <u>Annie White Raue</u>		Address <u>ton, Mo.</u>	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No.</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>Charles L. Raue</u>	Address <u>ton, Mo.</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gastro Intestinal hemorrhage</u> Ca of Stomach (Suspected) Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>—</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks.</u> <u>unknown</u>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour <u>—</u> a.m. <u>—</u> p.m. <u>—</u>	Month, Day, Year <u>—</u>		

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY	STATE
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21. I attended the deceased from <u>1957</u> to <u>Dec 8, 1960</u> and last saw him alive on <u>Dec 6, 1960.</u>	
Death occurred at <u>4 p</u> m on the date stated above, and to the best of my knowledge, from the causes stated.	

22a. SIGNATURE <u>J. L. Foster</u> (Degree or title) <u>MD</u>	22b. ADDRESS <u>Desloge Mo</u>	22c. DATE SIGNED <u>Dec 10, 60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>12/11/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery,</u>	23d. LOCATION (City, town, or county) (State) <u>Flat River, Missouri</u>
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24. FUNERAL DIRECTOR <u>Sparks Funeral Home Bonne Terre, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>Dec. 10, 1960</u>	26. REGISTRAR'S SIGNATURE <u>Esther Rudloff</u>
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Ewert Sparks

Licensed Embalmer No. 428

P. O. Address Bonne

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do so with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.